



May 4, 2009

Substance Abuse Coordination Committee
Department of Consumer Affairs
c/o Susan Lancara

re: Comments on Draft Uniform Standards in Areas #1 through #6

Dear Committee Members:

On behalf of the Center for Public Interest Law (CPIL), thank you for the opportunity to provide comments on the draft uniform standards in areas #1 through #6. I am unable to attend the May 6 workgroup meeting in person, so I appreciate your review of these comments.

For those of you who did not attend the Committee's March 3, 2009 meeting, CPIL is an academic and advocacy program that has monitored California agencies that regulate business, professions, and trades since 1980. After a competitive bidding process in 2003, I was selected as Medical Board Enforcement Monitor. In that position, I was charged with evaluating the Medical Board's enforcement and diversion programs. I published two reports (an *Initial Report* on November 1, 2004, and a *Final Report* on November 1, 2005), both of which are posted on CPIL's Web site at www.cpil.org. MBC's diversion program is addressed in Chapter 15 of both reports. As a result of the *Initial Report*, the legislature imposed a June 30, 2008 sunset date on MBC's diversion program to enable the Board to address the many deficiencies identified in the *Initial Report*. After a subsequent June 2007 audit by the Bureau of State Audits (which is posted on BSA's Web site at www.bsa.ca.gov), MBC unanimously voted to end the diversion program and it sunsetted on June 30, 2008. I offer the following comments based on my experience in auditing that program.

Draft Uniform Standard #1: Clinical Diagnostic Evaluation

First, a semantics issue. An evaluator should not be permitted to "determine" anything. An evaluator acts in an advisory capacity to a state board and/or its diversion program (if it has one). The evaluator should "evaluate," "opine," and "make recommendations" to the diversion program staff of a board or the board itself. Only the board or program staff may "determine" whether and under what conditions a licensee may practice. Allowing an outside third party (such as an evaluator or a DEC) to make decisions is the improper delegation of government police power authority to private parties.

Center for Public Interest Law ■ Children's Advocacy Institute ■ Energy Policy Initiatives Center
5998 Alcalá Park, San Diego, CA 92110-2492 ■ Phone: (619) 260-4806 ■ Fax: (619) 260-4753
717 K Street, Suite 509, Sacramento, CA 95814-3408 ■ Phone: (916) 444-3875 ■ Fax: (916) 444-6611
www.cpil.org ■ www.caichildlaw.org ■ www.sandiego.edu/epic
Reply to: San Diego Sacramento

It would appear that more research may be necessary on the “acceptable professional standards.” If a reputable entity (e.g., the American Psychiatric Association or the American Psychological Association) has developed standards for the conduct of a clinical diagnostic evaluation, those standards should be identified and referred to in this standard.

This standard appears to assume that there is one category of professional who is trained and qualified to provide the kind of multidisciplinary evaluation that many substance-abusing licensees may need — e.g., physical, psychiatric/psychological, etc. That may not be the case, and the standard should not make that assumption. The “accepted professional standards” (which should be identified) may mandate that a team of qualified professionals is needed to evaluate prospective participants, and that team may need more than 30 days. In my experience at the Medical Board, an initial evaluator would sometimes recommend subsequent additional evaluations by other professionals – and those evaluations might take 90-120 days (from intake) to reach Program staff. [During that entire time, by the way, the participant should be subject to immediate drug testing and, if appropriate, group meeting attendance requirements.]

The conflict of interest language is good, but it may be wise to include language to the effect that the evaluator cannot have had any of those relationships with the evaluatee “within the prior five years” (because what this language may do is prompt an evaluator to immediately sever ties with the evaluatee so he/she can say he/she does not now have a banned relationship with the evaluatee).

Draft Uniform Standard #2: Temporary Removal of Licensee from Practice

Based on my experience evaluating the Medical Board’s program (where no cease practice was required or even presumed), I favor a required temporary removal of the licensee from practice (what the Board of Registered Nursing calls a “cease practice”) at least until the clinical diagnostic evaluation has been completed and its results have been reviewed by the diversion program or program staff. Otherwise, you may be permitting a severely impaired licensee to continue to provide health care — which is not consistent with your statutory mandate to protect the public as your highest priority. A “cease practice” period gives the licensee an opportunity to concentrate on recovery without the stresses of work. If nothing else, a mandatory “cease practice” requirement would prompt the licensee to quickly arrange for and participate in the clinical diagnostic evaluation. Immediate and frequent drug testing should occur during the cease practice period, and the participant should not be permitted to return to work until he/she has demonstrated clean tests for a sufficient period of time.

Draft Uniform Standard #3: Board Communication with Licensee’s Employer

I favor board/program communication with the licensee’s employer, and not simply when the licensee is believed to be a threat. If (a) the licensee consents, (b) the employer inquires regarding the licensee, and (c) the licensee is satisfactorily complying with the terms and conditions of the program, I don’t see why the program could not share that information with the

employer. The employer should be viewed as – and encouraged to become – a partner in monitoring the participant/licensee, and should be communicated with frequently.

Draft Uniform Standard #4: All Aspects of Required Testing

Overall, these draft standards are a vast improvement over anything I ever saw at the Medical Board. Thank you for your good staff work and research on these draft standards, and their incorporation of required observed testing (anything less than that simply invites substitution or contamination, and defeats the entire purpose of testing) and compliance with national standards for specimen collector training, the testing location, the testing itself and the documentation of chain of custody of the sample, and the laboratory that tests the sample.

However, the frequency of drug testing suggested by the draft standard is insufficient. All diversion contracts require abstinence — complete abstention from the use of alcohol and unapproved drugs. “Random” drug testing 18-36 times per year (which is 1 to 3 times per month) is not testing for abstinence; it is testing for relapse, and the “random” testing we observed at MBC occurred largely on weekdays (and then largely on Tuesdays and Thursdays) to the exclusion of weekend days and holidays — thus allowing the participant to anticipate when he/she is most likely to be tested and least likely to be tested. This ability to “game” the system — which was documented by BSA in its 2007 audit — should be eliminated.

I favor far more frequent testing during at least the first year of participation (*e.g.*, 3-5 times per week), especially if the participant is permitted to practice. And that testing might not need to be random; it could be scheduled because it will be very frequent — at least for the first year or even two years, when recidivism is most likely. After that, testing can ease up somewhat.

If you are not going to test frequently for abstinence, and if you revert to the kind of “random” drug testing that occurs now, you must find a way to control the number of hours between the moment a participant knows he must be tested and the actual test. A system that requires a participant to call in daily might enable that participant to call in at 12:01 a.m. and learn that he/she must be tested by 6:00 p.m. that same day (18 hours later). That gives the participant plenty of time to flush his system with liquids (or other contaminants) or take other evasive measures to pass or avoid that drug test. At MBC, the collector called the participant on the appointed day, and the participant had to present himself for collection within 6 hours.

Draft Uniform Standard #5: Group Meeting Attendance

Here, you must question and reach consensus on the purpose of group meetings. If the purpose is to provide therapy, then the standard must require the group meeting facilitator to be a California-licensed professional who is qualified to provide therapy (in addition to experience in the treatment and rehabilitation of substance abuse).

If group meeting attendance is required, then group facilitators should be required to report unexcused meeting absences within 24 hours of the absence (not within 30 days). There is usually a reason that a participant skips a meeting. And that participant should be subject to an immediate test.

In my view, group meeting attendance should not be deemed to be required, especially if the participant is testing clean. Clean testing (if the frequency of that testing is adequate) is more important than group meeting attendance in terms of ensuring that participants who are using do not treat patients. Group meeting attendance should be required on a case-by-case basis for participants who benefit from it.

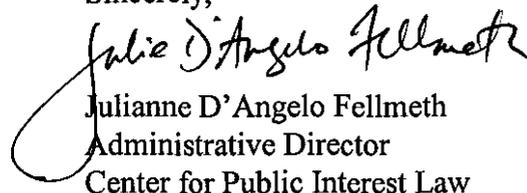
Draft Uniform Standard #6: The Necessity of Treatment

As with group meeting attendance, I don't think this standard should imply that drug treatment is required in all cases. It is not necessary in some cases. The factors you have listed are fine, but the standard should clarify that treatment may not be necessary in all cases. In my view, it would be better to require the participant to spend money on drug testing rather than on potentially unnecessary treatment.

I note that Dr. Tom Horvath, who has owned and operated Practical Recovery in La Jolla for almost 25 years, has also submitted comments on the draft standards. Just as a suggestion, it may be useful for the Committee to invite Dr. Horvath and others who do what he does to speak to the Committee at a future meeting, to enable Committee members to ask more pointed questions and avail themselves of his experience and expertise.

Thank you for the opportunity to present these comments.

Sincerely,



Julianne D'Angelo Fellmeth
Administrative Director
Center for Public Interest Law

Former Medical Board Enforcement Monitor